New Jersey Department of Health and Senior Services

CY 2005 FINANCIAL REPORT
LICENSED AMBULATORY CARE FACILITIES
SUBJECT TO THE AMBULATORY ASSESSMENT

Refer to the accompanying instructions to fill out this form.

Name and Address of Facility	License Number
	NJ Tax Identification Number

Line No.	Payer	A All Visits	B Gross Charges	C Gross Receipts
1	Medicare (Fee-for-Service and/or HMO)			
2	Medicaid (Fee-for-Service and/or HMO)			
3	Other Government Payer			
4	Commercial			
5	Self Pay			
6	Others			
7	Totals			

Voluntarily Submitted Information for Charity Care Services	A All Visits	B Gross Charges	C Gross Receipts
Reduced or No-Fee Care to Patients Based Upon Ability to Pay			

Certified By (Print Name)	Title	
Signature	Telephone Number	Date
Name of License Holder (if different from above)		
Signature	Date	